RELATING NURSING HOMES AND HOME CARE SERVICE TO THE HOSPITAL AND MEDICAL SERVICE BASE*

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IT seems only yesterday that many of us present here today were exhorting each other with the ideas of continuity of care and comprehensive health care, wringing our hands because we had neither the social climate nor the resources to put these ideas into effect. But reality has a way of catching up with ideas, and that is evidently what has happened to many of the ideas we have been espousing for years.

It may be useful, as my contribution on this occasion, simply and briefly to describe some of the developments in regional planning in one state, California, particularly as they affect nursing homes and home care services.

Just 5 years ago, the legislature established a program of state support for regional planning of hospitals and related health facilities and services. This was in response to the recommendation of a Governor's Committee on Health, and the general recognition that public interest required governmental participation in planning hospitals and related facilities and services beyond the Hill-Burton program and those lines on paper to which Dr. Milton Terris referred earlier, and beyond licensure. About the same time, really in parallel with this development, regional voluntary planning bodies largely under the leadership of hospital administrators and boards of trustees came into being in our state. These groups have functioned in parallel to the present time.

The legislature just last year changed the pattern somewhat toward greater reliance on the voluntary approach with state support. The state continues close cooperation and technical relationships with the regional planning groups through a staff supplying data and a statewide planning advisory committee.

Perhaps the most significant development recently has been the

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participation on a wider scale in this effort on the part of public interest groups such as labor, cooperatives, industry, and other such groups. I recall that about 15 years ago, under the initiative of the Institute of Industrial Relations at the University of California at Los Angeles, a group of labor people began to struggle with these problems. At that time, the group consisted primarily of some technical staff members concerned with health and welfare programs. Now we have a group that represents the very top leadership of labor in California; it is meeting consistently as its own group and with others on the problems in question. Last summer, following the report of the President's Commission on Heart Diease, Cancer and Stroke but before passage of the legislation for regional medical programs, the California Department of Public Health assembled a group including the deans of all the medical and public health schools, representatives of the State Medical Association, of the State Hospital Association, of the Cancer and Heart Association, and of the Department itself. Our purpose was to explore the implications of the recommendations of the Commission, the Michael E. De Bakey Commission, for our state. I think all of us who attended were surprised at the well-nigh 100 per cent attendance at the first and at almost all subsequent meetings. Everybody came because there was so much at stake. The group has continued to meet during the period when legislation has been passed and is being put into effect, and has agreed, furthermore, to continue trying to give leadership and coordination to efforts in California directed at obtaining maximum benefits from this important new legislation. Recently the group established itself as an incorporated nonprofit body with very careful allocation of the voting, although its decisions are really made substantially by consensus. The group has submitted an application for a statewide planning grant.

I might tell you something about the voting arrangement, as it was rather interesting. It happened that each dean came to the first meeting or, in a very few cases, sent an associate dean. Both the medical and the hospital associations came with three members. There happened to be one each from the heart and cancer societies. So we decided that for a committee of appropriate size, it would have a nice balance if we gave one vote to each medical school and to each school of public health, three to the State Medical Association, three to the Hospital Association, and one each to the other participants. This did achieve

a good balance among a number of rather delicate relationships: academic, community, and private medicine.

The aim is to assist the development of regional medical programs through studies, technical assistance, and advice to agencies that may be in a position to operate such programs. All of us involved in this work believe that the early bringing together of the major administrative and technical interests concerned with the new program offers a very great potential for development and for minimizing the friction that is so possible, in fact almost inherent, in a situation of this sort.

Meanwhile, most of the same people and agencies assembled in this group have been similarly deeply and cooperatively involved in the implementation of Title 18 and Title 19 of the Social Security Amendments of 1965. The California Title 19 program has been operating since March 1, 1966, involving an annual budget of more than half a billion dollars for comprehensive health services for about one million recipients of categorical welfare aid and less comprehensive benefits for an additional more than one million medically needy persons. These past few months have been a very interesting period.

To pick up the thread of the relationship between regional planning and nursing homes and home care services, it is necessary to go back a few years. Stimulated by the early demonstration at Montefiore Hospital, New York, N.Y., and other programs in the East, several hospitals in California, both private and public, organized coordinated home care programs. These have continued to grow, but slowly. We now have several of them. In some cases we have given support from departmental resources including federal funds. Meanwhile, local health departments and other agencies have established demonstration programs: for example, placing nurses and social workers in hospitals to assist in discharge planning for patients and to assist in actual arrangements for home care services by health department nursing or voluntary nurse services.

We had one rather interesting experience in this regard beginning about 10 years ago. The California Division of the American Cancer Society undertook a study of the needs of cancer patients. They were particularly concerned with the problem of how best to expend the resources of the Cancer Society, as these are limited, for services. There had been a great struggle going on here, as in many other parts of this country, over how a voluntary health agency should expend its

very limited resources to improve services for patients. After a 3-year study, and much evaluation of the report, the decision was made that the most important thing that could be done by the Cancer Society to improve the care of cancer patients was to connect the care given in hospitals with that given to patients after they left the hospital. And so, the Cancer Society has given a number of grants to hospitals to assist in this important phase of their work.

Further demonstrations have been concerned, for example, with the follow-up of patients discharged from hospitals with congestive heart failure. Here we learned from studies made in Florida that patients who did receive intensive follow-up care in their homes after discharge for treatment with congestive heart failure had to return to the hospital for repeated care to a considerably less extent than persons who did not receive such intensive home care.

These are the small but important projects that now bring us to the current situation. Reports of these several demonstration projects are now being made throughout our state at medical and hospital meetings, nursing association meetings, and the like. Coupled with funds now available from the Public Health Service to accelerate the development of home care programs that will meet the standards for Title 18, we are experiencing a tremendous boost in home care services.

In our state, also, we have determined that the standards for services under Title 19 shall be no less than those for Title 18. In fact, we are taking advantage of that part of the federal law that states that if the standards in the state established for the Title 19 program are higher than those instituted for Title 18, the Secretary of Health, Education, and Welfare is committed to adopt those same higher standards for Title 18 in that state. Most recently there has been formed an association of home care agencies to advise our department on standards for these types of services, just as we have advisory bodies now from the hospital and nursing home field.

The Hospital Association, seeing the importance of this home care development, is not leaving it to health departments and voluntary visiting nurse associations, but is now taking energetic leadership in stimulating home care programs with a hospital base.

I shall say just a very few words about nursing homes. The number of nursing home beds in California has more than doubled over the past few years, much more than doubled, under the stimulus of the

Kerr-Mills program. This has occurred without any standards beyond those of licensure. With the coming of Title 18 and Title 19 to our state, bringing a requirement for utilization review and transfer agreements, we look forward to a very rapid improvement in the quality of care in nursing homes. We are engaged now in a tremendous variety of meetings with nursing home, hospital, and medical people directed toward this end.

Just a few words now about some of the major problems that confront us in this whole endeavor. I have listed four.

One is the continuing isolation of most hospitals, nursing homes, and home care agencies. In spite of all our exhortations, demonstration projects, and reports, the fact is that the prevailing pattern is one of isolation. The question is whether the new ideas, the patterns of the demonstration projects, will take hold before the patterns of care rigidify. The new money that is now coming into the situation, the benefit structure that is being determined, and the new standards have stimulated a great state of flux, but this will not continue for long. The real challenge, the major problem, is whether we can move fast enough during the current state of flux really to achieve a significant improvement over what we have had.

The second problem is our past failure to reach important segments of the population with services: for example, services for those living in poverty-stricken areas. Recently at a meeting of the Advisory Hospital Council a representative from the Planning Body of Southern California showed us a map of the Los Angeles area on which he drew four lines. These lines encompassed an area with 250,000 people, in the center of Los Angeles, without a single hospital in it. Some of you may have heard of that community. Its name is Watts. On the outskirts of that community there were eight hospitals, two on each side. Of these eight hospitals, only one had more than 100 beds, and only two were accredited by the Joint Commission on Accreditation. In Delano a grape workers' strike has just been settled through adoption of the first labor contract for seasonal agricultural workers recorded in this country; and in other central valley communities, the local health departments have been endeavoring to develop health services for seasonal agricultural workers. Services have now been extended from county hospitals and from health centers in towns where thousands of people work and live close to the fields. Agriculture, one of the

biggest industries in our state, has least in the way of health services and other social advantages for those employed seasonally in it. The Medical Committee on Human Rights in California asked that the State Medical Association and the State Health Department join in looking into the Delano medical situation. This has been done. We do have tremendous problems in bringing health services to some people where they live and work, and we now have a climate that is favorable to the development of such services.

The third problem is the inadequate extension of services to patients afflicted by certain forms of illness: for example, alcoholism. One of the gravest health issues before our country now is up to the U.S. Supreme Court in a case carried by the American Civil Liberties Union. It is a case of drunkenness. The question is whether the man shall be penalized as a criminal or whether he shall be given care as a sick person. I think the settlement of that case may have a tremendous impact on health services.

The fourth problem is that there is need for stronger health service planning enterprise, both at the federal and at the state level. We are very fortunate in having at the present time a U.S. Surgeon General who has served as chief of the Division of Public Health Methods, which has been such a strong element in the development of regional planning in this country over the years. The passage of Senate Bill 3008 would lead to strengthening of the partnership and planning between the federal and state governments.

Finally, I should like to emphasize the main point that I have endeavored to make in these remarks: namely, that we are now encountering a tremendous challenge to our technical and administrative capacities. That challenge is whether we can really bring ideas that those of us present here today have cherished for two decades, ideas developed in demonstration projects, into public view and translate them into reality. To the regional planning that will take place under the program that Dr. Robert Q. Marston spoke of, the Title 18 and Title 19 benefits offer tremendous support. The issue is whether we can achieve new and better patterns of service before mass support will itself rigidify the services.

While we are now in a period of exciting motion, we ought to be deeply conscious of the fact that this condition will last only a short time. It is our responsibility to take the maximum advantage of it.